Open Enrollment 2012

State Employee Health Plan

Health Plan Comparison Chart *& other information*

For Active Employees

Kansas
Department of Health and Environment
Division of Health Care Finance

Health Plan Comparison Chart

	Plan A		Plan B		Plan C – With Health Savings Account (HSA)	
	Blue Cross and Blue Shield of Kansas Coventry/PHS UnitedHealthcare		Blue Cross and Blue Shield of Kansas Coventry/PHS UnitedHealthcare		Blue Cross and Blue Shield of Kansas Coventry/PHS UnitedHealthcare	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers	Network Providers	Non Network Providers
Basic Provisions						
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status					
Annual Deductible: not included in Coinsurance maximums in Plans A & B	$300 single/$600 family	$500 single/$1,500 family	$150 single/$300 family	$500 single/$1,500 family	*Note: When selecting any level of dependent coverage, the entire family deductible must be met before claims are paid for any covered person.* $1,500 single/$3,000 family	$2,000 single/$4,000 family
Coinsurance *(for all eligible expenses, unless otherwise noted)*	20% Coinsurance	50% Coinsurance	35% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
Annual Coinsurance Maximum *(Does not include Deductible and Copayments)*	$1,400 single/$2,800 family	$3,650 single/$7,300 family	$3,000 single/$6,000 family	$3,650 single/$7,300 family	N/A	N/A
Annual Out-of-Pocket Maximum	N/A	N/A	N/A	N/A	$3,000 single/$6,000 family *(includes Deductible and Coinsurance)*	$3,650 single/$7,300 family *(includes Deductible and Coinsurance)*
Lifetime Benefit Maximum	No limit	No limit	No limit	No limit	No limit	No limit
Covered Services						
Inpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Physician Office Visits						
Primary Care Provider	$25 Copayment	Deductible & 50% Coinsurance	Adults: $20 Copayment/ Dependent children age 18 and under: $10 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Specialist	$45 Copayment	Deductible & 50% Coinsurance	Adults: $40 Copayment/ Dependent children age 18 and under: $25 Copayment	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance

Urgent Care Center	$25 Copayment, Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	$25 Copayment, Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Emergency Room Visits	$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 20% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 35% Coinsurance	$100 Copayment (waived if admitted) then Deductible & 35% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 35% Coinsurance	Deductible & 35% Coinsurance	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance
Major Diagnostic Tests	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Rehabilitation Services: *(services limited to those medically necessary and appropriate: medical records must show continued improvement)*						
Inpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Outpatient Facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Office Based	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Durable Medical Equipment	Deductible & 20% Coinsurance: limited to $5,000 per person per year	Deductible & 50% Coinsurance: limited to $5,000 per person per year	Deductible & 35% Coinsurance: limited to $5,000 per person per year	Deductible & 50% Coinsurance: limited to $5,000 per person per year	Deductible & 20% Coinsurance: limited to $1,000 per person per year	Deductible & 50% Coinsurance: limited to $1,000 per person per year
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Antigen Administration: *desensitization/treatment; allergy shots*	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Autism Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Manipulation Therapies	Deductible & 20% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year	Deductible & 35% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year	Deductible & 20% Coinsurance: limited to 26 visits per year	Deductible & 50% Coinsurance: limited to 26 visits per year
Licensed Dietitian Consultation: *for medical management of a documented disease*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Mental Health						
Mental Illness & Drug or Alcohol Treatment	Same Coverage as Medical					

Preventive Care - *Limited to one visit or service per year unless otherwise noted. Review the benefit description for details on exact coverage.*	**Plan A Network**	**Plan A Non Network**	**Plan B Network**	**Plan B Non Network**	**Plan C Network**	**Plan C Non Network**
Well Baby Exams - *includes newborn screenings & age appropriate office visits*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Child Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Woman Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Man Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Prenatal Screenings and Counseling - *see benefit description for list of covered services*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Age Appropriate Bone Density Screening	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Immunizations	Covered In Full	Covered in full to age 6 otherwise Deductible plus 50% Coinsurance.	Covered In Full	Covered in full to age 6 otherwise Deductible plus 50% Coinsurance.	Covered In Full	Covered in full to age 6 otherwise Deductible plus 50% Coinsurance.
Mammography - *(not limited to one)*	Covered In Full	Deductible and Coinsurance	Covered In Full	Deductible and Coinsurance	Covered In Full	Deductible and Coinsurance
Colonoscopy - *(not limited to one)*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Ultrasonography for Aortic Aneurysm - *limited to men ages 65 to 75 with history of tobacco use*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Routine Hearing Exam	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Routine Vision Exam	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered

The comparison chart is NOT the governing document. Members need to refer to the Benefit Descriptions posted at ***www.kdheks.gov/hcf/sehp/BenefitDescriptions***

Health Savings Account - Only Available with Plan C

Plan C With Health Savings Account

	Full-Time Employee		Part-Time Employee	
	Employee Only	Employee + Dependents	Employee Only	Employee + Dependents*
Employer Contribution	$37.50 ($900.00 per year)	$56.25 ($1,350.00 per year)	$28.13 ($675.12 per year)	$42.19 ($1,012.56 per year)
Employee Contributions	$25.00 to $91.66	$25.00 to $204.16	$25.00 to $101.03	$25.00 to $218.22

**The HSA contribution maximums for Employee + Spouse, Employee + Children or Employee + Family are the same.*
Note: All columns represent 24 semi-monthly payments. The HSA total State Contribution for nine-month, Regents employees are distributed evenly over 16 pay periods each year.

Banking Institutions for Plan C - With Health Savings Accounts are:

- **Blue Cross and Blue Shield of Kansas - SelectAccount**
- **Coventry/PHS - UMB Bank**
- **UnitedHealthcare - American Chartered Bank**

For more information, go to:
www.kdheks.gov/hcf/sehp/PlanC

Caremark Prescription Drug Benefits for Plan A and Plan B

Tier	Type of Prescription Medication	You Pay	Your Out-of-Pocket Maximum
Tier 1	**Generic Drugs**	20% Coinsurance	There is a combined Coinsurance maximum of $2,580 per person per year that applies to Tiers 1, 2 and 3.
Tier 2	**Preferred Brand Name Drugs**	35% Coinsurance	
Tier 3	**Special Case Medications**	Maximum of $75 per standard unit of therapy	
Tier 4	**Non Preferred Brand Name Drugs**	60% Coinsurance	N/A (unless an override has been granted by Caremark)
Tier 5	**Discount Tier Medications**	100% Coinsurance	N/A
No Tier	**Anticancer Oral Medications**	25% Coinsurance to a maximum of $75 per standard unit of therapy	Separate Coinsurance maximum of $750 per member per year
Value Based	**Diabetes**	**Generic** — 10% to a max of $10/30-days **Preferrred brand** — 20% to a max of $20/30-days	Applies to the $2,580 Coinsurance maximum
Value Based	**Asthma**	**Generic** — 10% to a max of $10/30-days **Preferrred Brand** — 20% to a max of $20/30-days	Applies to the $2,580 Coinsurance maximum

*Preferred Drug list, specialty drug list and discount tier list available on the web at **www2.caremark.com/kse***

Caremark Prescription Drug Benefits for Plan C With Health Savings Account

Tier	Type of Prescription Medication	After Your Deductible You Pay	Your Out-of-Pocket Maximum
Tier 1	**Generic Drugs**	20% Coinsurance	There is a combined medical/drug coinsurance maximum of $3,000 per person/$6,000 per family that applies to both medical and prescription services
Tier 2	**Preferred Brand Name Drugs**	35% Coinsurance	
Tier 3	**Special Case Medications**	Maximum of $75 per standard unit of therapy	
Tier 4	**Non Preferred Brand Name Drugs**	60% Coinsurance	
Tier 5	**Discount Tier Medications**	100% Coinsurance	N/A
No Tier	**Anticancer Oral Medications**	20% Coinsurance to a maximum of $75 per standard unit of therapy	Applies to the combined medical/drug out-of-pocket maximum
Value Based	**Diabetes**	**Generic** — 10% to a max of $10/30-days **Preferrred brand** — 20% to a max of $20/30-days	Applies to the combined medical/drug out-of-pocket maximum
Value Based	**Asthma**	**Generic** — 10% to a max of $10/30-days **Preferrred brand** — 20% to a max of $20/30-days	Applies to the combined medical/drug out-of-pocket maximum

Prescription drugs covered by Plan C are subject to an annual Deductible and Coinsurance. Plan includes incentive program.

ASI Flexible Spending Account

	Health Care FSA for Plans A & B		Limited Health Care FSA for Plan C - DENTAL & VISION Services ONLY		Dependent Care FSA for Plans A, B & C	
Payroll Deductions	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
24 semi-monthly	$8.00	$208.33	$8.00	$208.33	$16.00	$208.33
16 semi-monthly	$12.00	$312.50	$12.00	$312.50	$24.00	$312.50

2012 Semi-Monthly Base Rates for State of Kansas Active Employees

Employee Category/ Annual Pay	Plan A			Plan B			Plan C			Delta Dental	Superior Vision Services	
	BCBS	Coventry/ PHS	UHC	BCBS	Coventry/ PHS	UHC	BCBS	Coventry/ PHS	UHC		Basic	Enhanced
Full Time 1: Less than $28,000												
Employee Only	$27.20	$27.42	$27.56	$26.74	$26.96	$27.10	$23.60	$23.71	$23.78	$0.00	$2.18	$3.63
Employee + Spouse	$113.75	$116.56	$118.43	$107.75	$110.56	$112.43	$74.37	$76.00	$77.09	$7.85	$4.36	$7.26
Employee + Children	$95.50	$97.76	$99.27	$90.66	$92.93	$94.44	$63.79	$65.10	$65.98	$6.28	$3.93	$6.53
Employee + Family	$180.86	$185.69	$188.90	$170.57	$175.39	$178.61	$113.30	$116.10	$117.96	$14.13	$6.10	$10.16
Full Time 2: $28,000 to $48,000												
Employee Only	$34.90	$35.35	$35.64	$33.95	$34.39	$34.69	$23.60	$23.71	$23.78	$0.00	$2.18	$3.63
Employee + Spouse	$124.12	$127.24	$129.32	$117.45	$120.58	$122.66	$74.37	$76.00	$77.09	$7.85	$4.36	$7.26
Employee + Children	$104.83	$107.38	$109.07	$99.40	$101.95	$103.64	$63.79	$65.10	$65.98	$6.28	$3.93	$6.53
Employee + Family	$195.35	$200.62	$204.12	$184.13	$189.39	$192.90	$113.30	$116.10	$117.96	$14.13	$6.10	$10.16
Full Time 3: More than $48,000												
Employee Only	$42.61	$43.29	$43.74	$41.17	$41.84	$42.30	$23.60	$23.71	$23.78	$0.00	$2.18	$3.63
Employee + Spouse	$134.47	$137.90	$140.19	$127.14	$130.58	$132.87	$74.37	$76.00	$77.09	$7.85	$4.36	$7.26
Employee + Children	$114.14	$116.97	$118.85	$108.12	$110.94	$112.83	$63.79	$65.10	$65.98	$6.28	$3.93	$6.53
Employee + Family	$209.86	$215.56	$219.35	$197.71	$203.40	$207.20	$113.30	$116.10	$117.96	$14.13	$6.10	$10.16
All Part-Time												
Employee Only	$96.48	$98.78	$100.31	$91.59	$93.88	$95.41	$58.24	$59.39	$60.15	$4.37	$2.18	$3.63
Employee + Spouse	$190.12	$195.23	$198.63	$179.23	$184.34	$187.74	$118.67	$121.63	$123.60	$14.27	$4.36	$7.26
Employee + Children	$165.92	$170.29	$173.21	$156.58	$160.96	$163.87	$104.63	$107.17	$108.86	$12.29	$3.93	$6.53
Employee + Family	$281.03	$288.86	$294.09	$264.33	$272.16	$277.38	$171.40	$175.94	$178.97	$22.20	$6.10	$10.16
HealthyKIDS Participants												
Employee + Children	$46.00	$46.78	$47.30	$44.34	$45.12	$45.64	$33.00	$33.39	$33.65	$1.40	$3.93	$6.53
Employee + Family	$127.56	$130.78	$132.93	$120.67	$123.90	$126.05	$68.40	$69.85	$70.82	$9.24	$6.10	$10.16

2012 Semi-Monthly Non-Tobacco User Discount Rates for State of Kansas Active Employees

Employee Category/ Annual Pay	Plan A			Plan B			Plan C			Delta Dental	Superior Vision Services	
	BCBS	Coventry/ PHS	UHC	BCBS	Coventry/ PHS	UHC	BCBS	Coventry/ PHS	UHC		Basic	Enhanced
Full Time 1: Less than $28,000												
Employee Only	$7.20	$7.42	$7.56	$6.74	$6.96	$7.10	$3.60	$3.71	$3.78	$0.00	$2.18	$3.63
Employee + Spouse	$93.75	$96.56	$98.43	$87.75	$90.56	$92.43	$54.37	$56.00	$57.09	$7.85	$4.36	$7.26
Employee + Children	$75.50	$77.76	$79.27	$70.66	$72.93	$74.44	$43.79	$45.10	$45.98	$6.28	$3.93	$6.53
Employee + Family	$160.86	$165.69	$168.90	$150.57	$155.39	$158.61	$93.30	$96.10	$97.96	$14.13	$6.10	$10.16
Full Time 2: $28,000 to $48,000												
Employee Only	$14.90	$15.35	$15.64	$13.95	$14.39	$14.69	$3.60	$3.71	$3.78	$0.00	$2.18	$3.63
Employee + Spouse	$104.12	$107.24	$109.32	$97.45	$100.58	$102.66	$54.37	$56.00	$57.09	$7.85	$4.36	$7.26
Employee + Children	$84.83	$87.38	$89.07	$79.40	$81.95	$83.64	$43.79	$45.10	$45.98	$6.28	$3.93	$6.53
Employee + Family	$175.35	$180.62	$184.12	$164.13	$169.39	$172.90	$93.30	$96.10	$97.96	$14.13	$6.10	$10.16
Full Time 3: More than $48,000												
Employee Only	$22.61	$23.29	$23.74	$21.17	$21.84	$22.30	$3.60	$3.71	$3.78	$0.00	$2.18	$3.63
Employee + Spouse	$114.47	$117.90	$120.19	$107.14	$110.58	$112.87	$54.37	$56.00	$57.09	$7.85	$4.36	$7.26
Employee + Children	$94.14	$96.97	$98.85	$88.12	$90.94	$92.83	$43.79	$45.10	$45.98	$6.28	$3.93	$6.53
Employee + Family	$189.86	$195.56	$199.35	$177.71	$183.40	$187.20	$93.30	$96.10	$97.96	$14.13	$6.10	$10.16
All Part-Time												
Employee Only	$76.48	$78.78	$80.31	$71.59	$73.88	$75.41	$38.24	$39.39	$40.15	$4.37	$2.18	$3.63
Employee + Spouse	$170.12	$175.23	$178.63	$159.23	$164.34	$167.74	$98.67	$101.63	$103.60	$14.27	$4.36	$7.26
Employee + Children	$145.92	$150.29	$153.21	$136.58	$140.96	$143.87	$84.63	$87.17	$88.86	$12.29	$3.93	$6.53
Employee + Family	$261.03	$268.86	$274.09	$244.33	$252.16	$257.38	$151.40	$155.94	$158.97	$22.20	$6.10	$10.16
HealthyKIDS Participants												
Employee + Children	$26.00	$26.78	$27.30	$24.34	$25.12	$25.64	$13.00	$13.39	$13.65	$1.40	$3.93	$6.53
Employee + Family	$107.56	$110.78	$112.93	$100.67	$103.90	$106.05	$48.40	$49.85	$50.82	$9.24	$6.10	$10.16

Delta Dental Benefits

	Delta Dental PPO Network Provider	Delta Dental Premier Network Provider	Non Network* Provider
Annual Benefit Maximum	$1,700 per member		
Lifetime Orthodontic Benefit Maximum	50% Coinsurance to a $1,000 per member		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	$50 per person per Plan year Not to exceed an annual family Deductible of $150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT Applies when you have NOT had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months			
Diagnostic and Preventive Services	Allowed amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

**Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.*

Your Coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

Superior Vision Benefits

Service or Item	Basic Plan: Network	Enhanced Plan: Network	Both Plans: Non Network
Eye Exams: Subject to $50 Copayment			
• Eye exam, M.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
• Eye exam, O.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
Eyeglasses: Subject to $25 Materials Copayment			
• Frame	Up to $100 retail*	Up to $100 retail*	Up to $45
• Single vision lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $31
• Bifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $51
• Trifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $64
• Lenticular lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $80
• Progressive lenses, pair	Not covered	Covered up to $165*	Not covered
• High index lenses, pair**	Not covered	Covered up to $116*	Not covered
• Polycarbonate lenses, pair**	Not covered	Covered up to $116*	Not covered
• Scratch coat	Not covered	Covered in full	Not covered
• UV coat	Not covered	Covered in full	Not covered
Contact Lenses: Not subject to Materials Copayment			
• When medically necessary	Covered in full	Covered in full	Up to $210 retail*
• Elective/cosmetic retail	Up to $150 retail*	Up to $150 retail*	Up to $105 retail*
Contact Lens Exam (fitting fee) ($35 Copayment)			
• Specialty contacts***	Not Covered	Up to $50*	Not Covered
• Standard Contacts****	Not Covered	Covered in full	Not Covered

**You are responsible for any charges above the allowance.*
*** You may only be covered for one pair of high index lenses or polycarbonate lenses under the Enhanced Plan (up to the allowance provided above).*
**** Specialty contacts are for new contact lens wearers or patients who wear toric, gas permeable or multi-focal lenses; includes two follow-up visits within three months of initial fitting.*
***** Standard contacts are for existing contact lens wearers of disposable, daily wear or extended lenses; includes two follow-up visits within three months of initial fitting.*

Notes:
- Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same plan year.
- For non network claims, Copayment amounts are deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.